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Paying Hospital-Based Doctors: Fee for Whose Service?

While most hospital-based specialist doctors are paid for procedures by provincial insurance plans, most hospital funding comes through a separate pipe, in the form of lump-sum amounts not linked to the number and quality of services provided. As a result, neither specialists' time nor hospital resources are efficiently used, contributing to high costs and long waiting lists.

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THE STUDY IN BRIEF

Canadian specialist doctors are paid mainly through fee-for-service for the procedures they perform. Nationwide, more than 80 percent of surgical specialists' income comes from fee-for-service payments that are negotiated collectively with provincial health ministries. Surgical specialists make up about 20 percent of all full-time equivalent physicians, and fee-for-service payments to them accounted for close to \$4 billion nationwide in 2011/12. Because physicians' decisions are the major drivers for most healthcare costs, getting the incentives right regarding the way doctors are paid is critical in ensuring Canadians receive good value for money from the healthcare system.

Whereas most hospital-based specialist doctors are paid via fee-for-service by provincial insurance plans, most hospital funding comes through a separate pipe, in the form of lump-sum amounts not linked to the number and quality of services provided. The result is a system in which neither specialists' time nor hospital resources are efficiently used, contributing to high costs and long waiting lists.

One contributing factor to waiting lists, and one reason why many recently graduated specialists in Canada are unemployed or underemployed, is a lack of complementary facilities, such as operating rooms, and the lack of complementary professionals, such as anaesthesiologists, nurses and so on. When a medical procedure requires hospital facilities as well as specialist time, the fee should be shared between hospitals and specialists in ways that give both a stake in producing high-quality care at low costs.

We propose that hospital-based physicians be paid directly from hospital budgets as opposed to the current practice of paying them separately through provincial insurance plans. Hospitals would then engage doctors and pay them appropriately – either by salary, fee-for-service, or a blend of methods. This would result in stronger incentives for providers to better deploy resources but may also lead to potential side effects, such as cost shifting and lower quality of care. In this Commentary, we discuss how incentives to both hospitals and doctors could be carefully designed to avoid pitfalls and to promote more efficient use of resources.

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Choosing the appropriate way to pay doctors is a critical element in any healthcare system. In Canada, total payments to doctors account for around 20 percent, or \$28 billion, of all government health spending (CIHI 2012a). But incentives inherent in the way doctors are paid can affect choices they make that influence other costs, such as for drugs, diagnostic services and hospital facilities.

Effectively, therefore, physicians' actions and recommendations are a major determinant of all healthcare costs. Their decisions also affect the waiting list times for many services or surgeries that, when coupled with the observation that many recently graduated physicians are underemployed or unemployed (Fréchette et al. 2013), serve as another sobering reminder that all is not well in our healthcare system.

Changing the incentives inherent in how doctors are paid could promote better value for money, especially if these changes are combined with emerging reforms in how hospitals are funded. In this *Commentary*, we propose that hospital-based physicians be paid directly from hospital budgets, as opposed to the current practice of paying them separately through provincial insurance plans. We propose also that physician costs be included in hospital funding models. Hospitals would be funded in large part by the type and volume of services provided, and the associated physician costs, rather than by lump-sum, global budgets.

Reform along these lines would promote more efficient utilization of physician and hospital resources, enabling healthcare providers to continue delivering needed, effective care.

How Doctors Are Paid

Most physicians in Canada today, whether family doctors or specialists, are paid principally through fee-for-service. The payment amounts per service are negotiated collectively with provincial health ministries.¹ While a broad definition of "specialists" includes medical non-procedural specialists who deal with diagnosis or management of various chronic conditions (e.g., geriatricians, hospital-based pediatricians, and medical oncologists), the focus of this *Commentary* is on specialist physicians that provide specific identifiable procedures, such as various types of surgery.

Nationwide, more than 80 percent of surgical specialists' income comes from fee-for-service payments (see Table 1). Surgical specialists

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- 1 That is, most of the doctors' income is derived from provincial insurance plan payments of bills they submit in which they list the various services they have performed.

Table 1: Percentage of Fee-for-service Payments in Total Physician Clinical Payments, by Province (2012)

	NL	PE	NS	NB	QC	ON	MB	SK	AB	BC	Average (non-weighted)
	<i>Percent</i>										
Family Doctors	73	63	n/a	61	70	47	62	64	n/a	86	66
Specialist Doctors	60	55	n/a	69	81	84	74	68	n/a	79	71
Surgical Specialties	73	77	n/a	82	88	87	82	76	n/a	n/a	81
Medical Non-Procedural Specialties	52	39	n/a	59	77	83	69	62	n/a	n/a	63

Sources: CIHI (2012b, 2013); National Physician Database.

also make up around 20 percent of all full-time equivalent physicians, and fee-for-service payments to them accounted for close to \$4 billion nationwide in 2011/2012 (CIHI 2013).² This represents a major share of the overall health spend, equivalent to the entire annual health budget of Nova Scotia.

While fee-for-service still dominates throughout Canada, the use of alternative payment plans is growing. Many doctors in “non-procedural” specialties are paid also at least partly through fixed salaries or sessional fees. Roughly 40 percent of these specialists’ incomes are paid by means other than fee-for-service. In some provinces – especially Ontario – family doctors in primary care now receive less than 50 percent of their income through

fee-for-service. Much of the rest comes in the form of capitation, whereby doctors are paid a fixed amount for each patient registered in their practice, in return for agreeing to provide them with all the services they need from among those specified in the capitation contract.

The trend toward more capitation use in primary care is not surprising. It is widely recognized that paying family doctors through other methods than pure fee-for-service, including methods partially based on capitation, are likely to do a better job of aligning incentives in primary care with the interests of taxpayers and patients (Christianson and Conrad 2011, Léger 2011). Capitation payments are growing in popularity in a few provinces because they reward primary-care doctors

2 Many hospital-based physicians also provide care and earn income in other settings such as private clinics or their own practices outside of hospitals. The authors are not aware of any data that distinguish fee-for-service payments to specialists based on the location of care. While we focus on the care provided in hospitals in this *Commentary*, we comment briefly on the role of private clinics later in the paper.

who are productive in the sense of performing the diagnostic, referral and managerial functions for many patients rather than a large volume of services to individual patients.³ Capitation payments can reduce the number of people without a family physician, allow patients to see their doctor more quickly, and encourage family doctors to keep their patients healthy.

While capitation may be a more efficient payment method for family doctors than fee-for-service, the situation for most specialists is different. They perform services on patients who have, or may have, a condition that cannot be properly diagnosed or treated at the primary-care level. For doctors whose task is to supply well-defined procedures, the most straightforward way of encouraging them to be productive is to pay them based on the number of procedures they perform, as fee-for-service does. Although it has been criticised because it may encourage doctors to perform more services than necessary, fee-for-service nevertheless seems like an effective way to pay physicians when the main objective is to reduce, and prevent the growth of, waiting lists, as typically is the case in most Canadian provinces today.

However, although most fee-for-service doctors who perform specialist services have an incentive to provide a large quantity of services, this payment approach has not made our system deliver services efficiently. Waiting lists for many kinds of surgery across Canada continue to be a major problem. Indeed, the Health Council of Canada observed that Canada has the worst ranking among comparable high-income countries in terms of the percentage of patients who reported that they had had to wait for over four months for elective surgery (Health Council of Canada 2013).

Issues with the Current System

For some kinds of procedures, waiting lists exist simply because the number of available specialists has been too small to meet the demand. For others, however, the problem is a different one: a lack of access to the complementary hospital resources and personnel that are required, along with the specialists' time, in performing the procedures.

Waiting lists that exist because there is a shortage of hospital facilities may, of course, also simply reflect a lack of capacity. But sometimes the waits may be due to other factors, such as unavailability of ancillary professionals when they are needed, or deficiencies in the way scheduling and wait lists are managed. To the extent the waiting lists reflect inefficient management of these complementary inputs, increasing the incentives for doctors to be productive by raising their fees will do nothing to improve the situation. What is needed instead is better incentives for those who make the decisions regarding the ancillary inputs; i.e., those who manage the hospital resources. As we discuss below, governments in some provinces have been trying to introduce such incentives in recent years.

The current system of fee-for-service payments for physicians has also been criticized for not taking quality of care into account. While there is broad debate about the right way to measure quality of care – proposed methods include patient-reported outcomes, rates of readmission or infection, and so on – there is so far little agreement on how to properly adjust fee-for-service payments to reflect such measures. In any event, the current funding system does not imply effective incentives for either physicians or hospital managers to adhere to any existing quality-of-care performance benchmarks.

3 Blomqvist and Busby (2012) have a more complete discussion of the advantages and disadvantages of capitation payment models in primary care.

In both Canada and the United States, the challenge of controlling healthcare costs and promoting timely high-quality care is further complicated by the fact that the specialist manpower and hospital resources that produce these services are independently managed and funded. Even when they treat patients in a hospital, specialist physicians in both countries typically practise as autonomous self-employed professionals and are funded separately from the hospitals where they work.

In Canada, healthcare financing is bifurcated. Physician fees are paid through provincial health insurance plans, while hospitals are funded through a separate budget envelope. As well, responsibility for quality of care is divided between the doctor and the hospital, both of which are funded by, and accountable to, different agencies.

At the local level, this divided responsibility may create obstacles to productivity-enhancing initiatives. As an example, hospitals have found it difficult to introduce new reporting systems or wait-list management practices because, as autonomous agents, physicians do not report to hospital management. At the provincial level, this dual accountability system complicates the tasks of reducing waiting list times while controlling costs and maintaining quality of care. As a result, health ministry officials often lack the information to tell whether problems in a particular region and/or specialty are related mostly to hospital-side inputs or simply reflect a lack of physician resources. Therefore, it is difficult to determine which local decisionmaker should be given responsibility for dealing with them.

Although it is difficult to know the extent to which the divided responsibility has raised costs or

had an impact on quality of care, it is reasonable to believe that closer integration, funding and management of the two types of resources could improve efficiency. The idea that provinces could make more productive use of healthcare resources by integrating the funding of the services of doctors and hospitals for certain kinds of services is compelling. We believe provinces should consider reforms under which the services of hospitals and specialist doctors would come from the same budget and that a single decisionmaker have responsibility for both aggregate costs and the quality of care delivered at the local level.

In moving in this direction, provinces could draw on lessons learned elsewhere. The funding models in most European countries differ from ours in that hospital-based specialists typically are not funded independently of the hospitals in which they work. Instead, they are paid by the hospitals out of the funds they receive from government or social insurance plans. In the United Kingdom and Denmark, for example, hospital-based specialists usually are salaried hospital employees, like nurses (see Table 2). In other European countries, hospital-based specialists may be paid at least partly through fee-for-service but from the same budget as the hospital where they treat their patients.⁴ Even in the United States, where most specialists are paid independently, as in Canada, there is now a trend toward more use of integrated payment models under which their payments come from budgets shared by hospitals and other providers (such as primary-care doctors). In this way, all parties have an interest in working efficiently together to keep costs low (Sutherland et al. 2013).

4 In some cases – for example, in France and the Netherlands – the fees are uniform across hospitals and are determined through collective agreements.

Table 2: Specialist Remuneration in Canada and Select OECD Countries

Country	Budget Source	Are Physician Expenses Paid From Hospital Budgets?	Primary Method of Payment	Self-Employed
Canada	Provincial ministries of health	No	Fee-for-service	Yes
UK	Regional health budgets	Yes	Salary	No; but full-time specialists can earn 10% of their income from private practice via fee-for-service
Netherlands	Mainly private insurance funds; also state funds for long-term illness	Yes	Fee-for-service	Most are self-employed; salaried specialists may supplement incomes with private practice
France	Mainly hospital budgets; also national social insurance system	Yes, hospitals withhold a share of physician compensation to cover the costs of facilities and equipment	Mixed (fee-for-service and salary)	About half of specialists are self-employed, but full-time specialists can earn 30% of their income from private practice via fee-for-service
Germany	Social insurance system, hospital budgets and private billing that requires doctors to reimburse hospitals for facility and equipment costs	Yes	Fee-for-service; some salary	Yes, mostly
Denmark	Hospital budgets	Yes	Salary	No, but may run separate private practice to supplement income

Sources: OECD (2008) and other government documents.

NEW WAYS TO PAY DOCTORS AND HOSPITALS

If we were seeking only a better balance between specialist and hospital resources, it might be accomplished simply by allocating more money to the hospitals so that they could build more operating rooms and hire more nurses. But it might also be possible to reach a better balance and attain better value for money by raising the efficiency

with which hospitals use their resources. Hospital productivity, measured by the number and quality of successful interventions given the inputs used, in turn, depends in part on the incentives that hospital decisionmakers face. A move toward a model under which funding for hospitals and their specialists comes from the same budget would be particularly likely to yield efficiency improvements if it were combined with new methods of paying hospitals for each service.

In many countries, policymakers have recognized that better productivity and reduced waiting lists require improved incentives for hospitals, not just for the doctors working within them. They have, therefore, moved toward funding models in which hospitals' revenue is more explicitly tied to measures of the services they provide and their quality rather than global budgets. In the latter model, each hospital's annual government grant is a fixed amount determined in an opaque way by many factors, including purely political ones, and is adjusted only slowly as circumstances change. Even in Canada, government and hospital administrators now widely recognize that there is a strong case for paying hospitals in some way other than through global budgets, as most OECD countries already do.

In the pursuit of the most effective method for providing patients with access to timely quality care, some Canadian provinces – notably Ontario and British Columbia – have taken tentative steps in the direction of Activity-Based Funding (ABF), which pays hospitals according to the services they provide for admitted patients (Sutherland et al., 2013). The United States adopted a form of ABF (also referred to as “case-based” funding) in the early 1980s. Referred to as payment by Diagnosis Related Group (DRG), versions of this DRG model were adopted in the early 1990s in Sweden, Australia and Italy, and in the late 1990s and early 2000s in Norway, Spain, Japan, Finland, Denmark, England and France (Ontario 2012). Germany was a latecomer but introduced the model in 2005. In joining the fray in the last few years, Ontario and British Columbia are thus following not only the US DRG model, but also those of most European

systems (see Box 1 for more detail on the ABF reforms in Canada).

While all countries have used different ABF versions, they all share certain features. In particular, they all tend to be “prospective,” meaning that what the hospital receives for treating a patient with a certain condition depends principally on the nature of his or her health problem (and perhaps certain characteristics such as co-morbidities, age and so on), but not on the volume of different services that were utilized in the course of treatment.⁵

An approach that integrates hospital and specialist funding would still apply the principle that a hospital receives a fixed amount for patients in a given category, but would insist that this amount covers both the hospital's costs and payments for the relevant specialist services. How the specialists themselves would be paid would be determined on the basis of the contractual arrangements between them and the hospital. It could be on the basis of salary, fee-for-service or some combination of the two. In a transition to this type of system, the first step would be simply to add the fees payable to physicians under the current model to the payment the hospital receives for each case.

Challenges with Reform: Balancing Incentives, Quality of Care and Physician Autonomy

As with other institutional changes, reform of hospital funding and hospital-based specialist services would no doubt be controversial. While a new set of incentives could produce better use of resources, resulting in shorter waiting lists, critics have observed that they may also cause hospitals to skimp on the resources they spend

5 As an example, the basic principle underlying the oldest version, the US DRG model, is that the amount that a hospital receives for treating a patient who is covered by Medicare (which covers all US citizens over age 65) will depend only on the diagnostic category in which the patient is specified on admission, regardless of what services he or she receives before they are discharged. While this is the underlying principle, various exceptions are made for cases that turn out to be particularly difficult to treat, etc.

Box 1: The Emergence of Activity-Based Funding Reforms in Canadian Hospitals

Canada's provinces generally fund hospitals with global budgets, which are fixed amounts based on historical levels, adjusted mainly for population catchment areas. But global budgets do not match up well with healthcare efficiency goals, as well as the growing need for more value for money and access to hospital-based services. Hence, provinces are starting to move away from global budgeting toward more patient-based or activity-based funding (ABF) models. Ontario and British Columbia are two examples. For an in-depth analysis of these changes, see Sutherland et al. (2013).

Ontario

Global budgets have, prior to last year, accounted for nearly all the provincial funding for hospitals, but this is changing. In 2013, global budgets are projected to make up roughly 45 percent of all hospital funding, and in 2014 only 30 percent of hospital funding is planned to come from this source.

Starting this year, the province's Health-based Allocation Model (HBAM) and Quality-Based Procedures (QBP) funding accounted for more than one-half of all hospital funding. HBAM, an evidence-based funding model that considers factors such as age, gender, socioeconomic status, rural geography and patient flows, is planned to comprise some 40 percent of all hospital funding by 2014.

HBAM uses an econometric model to predict hospitals' cost per service, adjusting for other factors, including the acuity of patients, expected population growth, the size and teaching status of a hospital, and so on.

The remaining 30 percent of 2014 hospital funding is expected to come from QBPs. QBPs pay hospitals based upon the best practice cost of delivering an identifiable service – costs that cover in-patient stays and the treatment given to a patient while in hospital, but currently do not include physician costs. By paying the hospitals per case, but specifying evidence-based guidelines for the treatment of patients with a similar clinical ailment, financial incentives are introduced so that hospitals implement best practices that keep costs at or below the payment amounts while still delivering high-quality service.

At the time of writing, the list of QBP services eligible for special funding includes:

- hip replacement;
- knee replacement;
- dialysis and other treatments for chronic kidney diseases;
- cataract surgery;
- congestive heart failure;
- stroke;
- chronic obstructive pulmonary disease;
- elective vascular surgery;

Box 1: Continued

- chemotherapy; and
- colonoscopy

The Ministry of Health and Long-Term Care has created expert panels for each QBP that are tasked with developing best practices for treating these conditions. Their job is essentially to identify the best evidence-based care pathways and to focus exclusively on quality performance. The ministry then plans to assign costs to each QBP to reflect the full continuum of care outlined by its panel, and adjust for acuity and quality. Progress is coming, but thus far incomplete.

British Columbia

British Columbia is introducing a patient-focused funding system, covering a smaller share of total hospital funding than in Ontario. In British Columbia, regional health authorities receive funds from the health ministry that they, in turn, allocate to hospitals. Approximately 15 percent of regional health authorities' budgets for acute care are based on their hospitals' annual activity, in terms of the number of services provided. Small hospitals are excluded from volume-based allocation decisions because of their limited exposure to local competition for hospital-based services.

Financial ABF incentives are aimed at regional health authorities, which are then responsible for communicating them to hospitals. Physician costs are, like in Ontario, excluded from funding under these plans and are paid mainly via fee-for-service.

In April 2010, the province introduced Patient-Focused Funding, to be implemented by the newly created Health Services Purchasing Organization (HSPO). HSPO, under a three-year mandate, was to create financial incentives for effective, efficient and high-quality healthcare. In July 2013, the province announced plans to gradually phase out the HSPO and have the ministry of health assume responsibility for HSPO's activities while maintaining the principles of the original ABF model.

ABF reform here has several components. There is a general ABF program, specified as a percentage of total hospital budgets, and then there are a few sub-programs such as the Emergency Department Pay-for-Performance Program and the Procedural Care Program to reduce wait times for certain surgeries. Under the Procedural Care Program, hospital administrators determine a price to pay for additional surgical care beyond specified threshold volumes. (See Sutherland et al. 2012, for more details on BC's ABF reforms.)

on each case, producing worse health outcomes. Alternatively, they may shift costs from hospitals to the community and other providers if patients seek more care from non-hospital providers as a result of being discharged "quicker and sicker." By the same token, a suggestion that better financial integration of hospital and specialist services could be accomplished by having doctors become hospital employees may be resisted on the grounds that they don't want to give up the autonomy that they have as self-employed practitioners.⁶

These concerns existed in the countries that moved in this direction at an earlier time. While they have not disappeared, there is evidence to suggest that the undesirable side effects of productivity-enhancing incentives have not been as great as originally feared.⁷ The negative risks pointed out by critics can be mitigated, in part, by a better balance of incentives.⁸ Health system financing models elsewhere have been modified in ways that moderate the strength of the incentives or combine them with offsetting incentives on producers to maintain quality (Sutherland et al., 2013).

For example, the US Medicare plan is experimenting with changes that would offset the incentives inherent in DRG to shift costs to out-of-hospital healthcare providers. This includes moving to funding models under which a single DRG-payment is made to cover not only the

hospital's own costs, but also the cost of specialists and post-acute providers for treatment of specific health problems within a specified time period following the initial intervention. Provisions in the Obamacare reforms – formally known as the *Patient Protection and Affordable Care Act* (2010) – include proposals for such bundled payments.

Under a five-year pilot program that began in January 2013, these payments cover not only physician services delivered inside and outside an acute-care hospital, but also post-acute care services. The pilot program rules also require reporting on a set of quality measures, such as rates of hospital readmissions, community discharge rates, acquired hospital infections, etc. Policymakers in Canada stand to learn a lot from this US initiative. Importantly, the next generation of these models will move toward a system where payments explicitly incorporate quality-of-care measures – an approach that Canadian provinces probably will need to adopt in the future in order to assure the public it is getting value for its tax dollars.

A payment model that integrates funding for hospitals with compensation of specialists could also accommodate Canadian doctors' preference for self-employment. In other countries, an approach that partially accomplishes this balance permits physicians' hospital contracts to allow them to practise privately on a part-time basis. This type of

6 They may also be concerned that they will not be adequately compensated for giving up some of the advantages that self-employed individuals enjoy with respect to the taxes they pay.

7 A recent comprehensive review of studies that have addressed this issue concludes that, "[In] general, the findings of studies in this area, taken together, provide little compelling evidence that financial incentives designed to reduce or control costs or utilization have had a negative impact on the quality of care." (Christianson and Conrad 2011, 637).

8 Sweden's movement toward an ABF system in 1992 is informative because reforms there applied only to a select group of health regions – other regions were left under the old global budget scheme. Inter-regional comparisons, therefore, could be used for empirical estimates of the reforms' impact. That said, however, the ABF reforms were coupled with an assortment of other changes to encourage greater competition within the health system, making it less easy to identify what changes were attributable to ABF funding. The reforms produced initial cost savings of around 13 percent and led to immediate productivity gains and lower wait times (Kirby 2002). But in most regions, hospitals later found ways to increase volume beyond expectations, raising aggregate costs again. In response, regions devised ways to update payment levels periodically and imposed limits on reimbursable volumes (Kastberg and Siverbo 2007).

arrangement has been used for a long time in the United Kingdom, where specialist services under the National Health Service (NHS) are supplied in hospitals by consultants who are salaried employees but can earn additional income by treating patients willing to pay privately for the specialist of their choice. Currently, only a few provinces permit doctors who receive payments under provincial plans to supply similar services to patients who pay privately. However, an arrangement under which specialists received part of their income in the form of a salary from a hospital and another part from provincial plan fees for services that they supplied outside the hospital would clearly be compatible with current rules (Boychuk 2012).

Hiring specialists as employees on a fixed salary is only one way in which hospitals can pay for their services. They can also do so through contracts under which hospitals pay doctors a negotiated fixed amount for each patient they treat. Under this model, the doctors remain self-employed in the same sense that they currently are and continue to be paid on the basis of fee-for-service. The only difference would be that the fee levels would be negotiated at the hospital level, not for each province as a whole.⁹

This, in turn, raises the question as to whether local bargaining with specialist physicians might result in higher costs. Clearly, where there is a

shortage of practising specialists, competition among hospitals for their services could cause physician costs to rise above current levels. But Canada is now experiencing an oversupply of physicians in many specialty areas – such as cardiac, neuro and orthopedic surgeons – due in part to limits on hospital and operating room time (Fréchette et al. 2013). In those areas, local negotiations should not increase cost pressures. Further, the pricing signal that results from bargaining with doctors would give an indication of the demand pressures of the local acute system and, in the long run, result in better matching of medical school graduates with the needs of the system than the current system of collectively negotiated fees.¹⁰

An Alternative Approach: Letting Specialists Pay for Hospital Facilities

Having hospitals pay for the services of the specialists who treat their patients is one approach to attaining a more coordinated and efficient use of manpower and hospital capacity. However, there is an alternative method for integrating the funding of specialists with the facilities they need – requiring them to pay for the use of hospital facilities.

Under either method, provincial governments would start by estimating the total cost of providing the procedures involved, including hospital costs

9 A possible objection to this approach is that negotiation of individual contracts between specialists and hospitals would be more complicated and costly than the current system under which provincial medical associations bargain centrally with governments. On the other hand, locally established contract terms would, in principle, be more sensitive to local market conditions, which might indirectly result in a better geographic distribution of specialists.

10 One consideration that has been drawn to our attention is that with salaried doctors (or possibly even with doctors working under individual contracts), the cost to hospitals would be raised as a result of their becoming liable for payment of payroll taxes on doctors' income. While this may be true, it is irrelevant from the viewpoint of the taxpayer, since the additional cost to provincial governments would revert to government as incremental tax revenue.

A more substantive objection is that reform along these lines might be resisted by provincial physician associations who might prefer to assert their right to engage in province-wide collective bargaining, rather than under the different terms that would result from differences in local market conditions. Be that as it may, many of the advantages of making hospitals responsible for contracting with doctors for their services could still be realized even if the terms were to be collectively negotiated.

and physician compensation.¹¹ With the approach we have discussed above, the government would fund hospitals on the basis of these estimates. The hospital would then pay doctors for their services, according to the terms they have negotiated.

Under the alternative approach, the government transfers the estimated amount for each type of service to the specialist who then pays the hospital for the use of its facilities. The specialist payments would reflect the costs to the hospitals of providing the facilities and would, in principle, be established through negotiations between the specialists and the hospitals.

The revenues that hospitals would expect to receive through these arrangements would be taken into account in establishing what additional amounts provincial governments might provide them for other activities. Examples of this approach already exist. In France, for one, revenue from charges on physicians that reflect the cost of providing services such as operating room overhead, nursing hours, etc., is taken into account in determining the amount of funding that hospitals will get from the social insurance system.

Combining the funding streams of specialist and hospital services for certain kinds of treatment has the advantage of allowing doctors to remain self-employed. This approach could also be used to create a level playing field for competition between hospital-based care and care in independent clinics. Depending on the specialty and the cost at which hospitals are willing to provide the required facilities, some doctors might find that it would save costs to treat patients in their own clinics

rather than in hospitals. In certain medical areas (including orthopedic surgery) there already are Canadian examples¹² of private clinics that are capable of competing with the public system if given the opportunity (Alberta 2006). In some cases, the nature of the procedures involved may make it possible to treat patients in independent specialized clinics at costs that are no higher than those that would be incurred in an efficiently managed hospital.

In other cases, especially for patients with complex problems requiring many kinds of diagnostic services and treatment, care in a hospital may inherently be more efficient in principle. However, even in such cases, the threat of competition from independent clinics may serve as a useful incentive for hospital managers to use their resources efficiently and reduce the cost at which they could offer facilities to specialists.¹³

A potential problem: supplier-induced demand

An implicit goal in the preceding discussion is how best to increase specialist productivity with existing resources, potentially shortening waiting lists. But as experience elsewhere has shown, provider incentives may end up being so effective that they give rise to another problem – rapidly increasing aggregate costs as the number of procedures expands beyond what is justified in terms of health benefits.¹⁴

In reality, the specialists who perform most major procedures are also often the only ones with the diagnostic expertise to decide whether a patient's problems require such a procedure or

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- 11 The availability of good data – or willingness to share data among provinces – is an important foundation for implementing the reforms suggested in this paper. Such data are also a prerequisite for a move toward ABF financing arrangements.
 - 12 They are especially common in Quebec, Alberta and British Columbia (Glauser 2011).
 - 13 One of our colleagues has pointed out that, in principle, the two funding models could co-exist. That is, the government could simply announce the amount of combined funding it was willing to pay for a specific procedure and then allow both hospitals and specialist clinics to compete for the right to perform that procedure.
 - 14 Again, the experience of Sweden (see footnote 8) is particularly illustrative.

whether their problems can be handled using simpler and less expensive methods. Referral requirements from primary-care doctors before a patient can see a specialist can help reduce the number of patients they see, but typically they have further choices upon examination: for example, whether a person's heart condition can be managed through medication or an operation is needed. If these choices are made by the same specialist who performs the major procedure when it is needed, linking the specialist's income to the number of procedures he or she performs gives rise to the classic conflict of interest – "supplier-induced demand" (SID), when major procedures can be performed on patients whose conditions could be managed in less expensive ways. While this problem is most obviously relevant in cases where the specialists themselves are paid via fee-for-service directly, it may also apply, at least to some extent, in cases where the revenue of the hospitals is linked to the number of procedures, even when the doctors who perform the procedures are paid by salary.

Giving family doctors some degree of incentive to limit referrals to specialists in cases where it is feasible to manage patients' problems at the primary-care level is one way to manage the SID problem. Moreover, when payors (the provincial governments) fund hospitals or specialists a fixed amount per case, their contracts with providers can specify target volumes, so that full payment per case at the negotiated rate is limited to a specific number of cases. A lesser amount per case is paid for procedures beyond the target level. (The ABF funding system used in British Columbia already incorporates this idea; see Box 1.)

Furthermore, in cases where specialists are faced with choices between major procedures and other ways of dealing with a patient's condition, the payor must decide not just on what fee should be paid for

the major procedure but also for the services that are needed when patients are managed in other ways. If hospitals and doctors are paid relatively well for the more conservative treatment choices, the implicit incentive to recommend major procedures is reduced.

RECOMMENDATIONS

The problem of how best to pay specialists and hospitals for their services illustrates that there is no such thing as a free lunch. And because hospital-based specialists account for a large share of the \$16 billion fee-for-service payments made to Canadian doctors in 2011/2012, getting the incentives right is important. Stronger incentives for providers may be effective in better deploying resources, but they may also give rise to side effects in the form of cost shifting or lower quality of care, if they are not carefully designed.

That said, while one must recognize that dealing with these side effects may be difficult and costly, one must also remember the inefficiency costs that these reforms are intended to overcome. In reality, sticking with the status quo would not encourage the best use of limited public resources and would also ignore the need for better value in health spending as the aging population demands increasing volumes of procedures. Comparisons of Canada's provincial health systems with those in other countries suggest that over the past 30 years, the counter-arguments, or the calculated political risks from change, to potential efficiency-enhancing reforms often carry too much weight with politicians. Other comparable countries are arguably much further along in terms of finding ways to address efficiency issues in their health systems.¹⁵

In Canada, specialist doctors continue to derive the bulk of their income by billing their

15 See, for example, Health Council of Canada (2013).

provincial insurance plans for the services they have performed on the basis of fees that have been negotiated between their associations and the provincial plan. Most hospital funding, on the other hand, continues to flow through a separate pipe, in the form of negotiated global budgets under which hospitals are paid periodic lump-sum amounts that are not directly linked to well-defined measures of the services they provide. The result is a system in which neither specialists' time nor hospital resources are efficiently used, and hospitals have little ability to independently institute changes to practise because of physician autonomy. As a result, high costs and long waiting lists remain significant problems in many places.

While we support the trend toward payment methods other than fee-for-service for primary-care physicians and in so-called non-procedure specialties, the fee-for-service system has advantages as a way of paying specialists whose work, to a large extent, consists of performing major procedures. It implies an incentive to increase the volume of services and reduce waiting lists. On this score, fee-for-service, as long as it does not lead to increased surgeries that could be more cheaply managed, is a good thing for many surgical specialists.

However, the main reason why waiting lists exist in many, if not most, cases – and why many

recently graduated specialists are unemployed or underemployed – is not that doctors have insufficient incentives. Instead, the problem is a lack of complementary facilities, such as operating rooms, and/or the lack of complementary professionals such as anaesthesiologists, nurses and so on. When a medical procedure requires hospital facilities as well as specialist time, the fee should be a payment that covers both, and the fee should be shared between the hospitals and specialists in ways that give both a stake in producing high-quality care at as low a cost as possible.

Canadian provinces are laggards when it comes to reforming hospital financing. Current fee schedules could provide the basis for transitioning to a new model of paying hospitals and specialist doctors without too much disruption. And future payment systems could begin to incorporate measures of care quality into the financial transfers, improving accountability to patients for services provided. Moving simultaneously toward new approaches to determine how hospitals will be paid and toward a closer integration between the funding of hospitals and the specialists who treat patients in them could yield substantial payoffs in terms of better overall health-system performance.

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